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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V.S. AT 15 ME  
SM 2/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10110

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY CHARLES MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY CHARLES	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Waldorf - Rural		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X WALDORF BOX 89 C	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS 1 Holly Hill Drive	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)	First JAMES	Middle EDWARD	Last Brown
4. DATE OF DEATH	Month 9	Day 27	Year 1958
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 15, 1910
9. AGE (In years last birthday) 48 yrs.	10. IF UNDER 1 YEAR Months 0 Days 0 Hours 0 Min. 0	11. IF UNDER 24 HRS. Months 0 Days 0 Hours 0 Min. 0	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) EMPLOYEE		10b. KIND OF BUSINESS OR INDUSTRY N.C. Govt Water Dept.	
11. BIRTHPLACE (State or foreign country) Greensboro, No. Carol.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME H.T. BROWN		14. MOTHER'S MAIDEN NAME MATTIE BROWN	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) NO		16. SOCIAL SECURITY NO. —	
17. INFORMANT MIS. Beatrice Brown - wife -		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 823 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO		Cerebral Hemorrhage 9-27-58	
CONCUSSION 9-27-58		Auto Accident 9-27-58	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Auto turned over - Highway	
20c. TIME OF INJURY Month, Day, Year Hour 5 p.m. 9-27 1958		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Highway	
20f. (City or town) WALDORF CHAS MD		(County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>E.J. Edelen</i>		DATE SIGNED 9-18-58	
EXAMINER'S NAME (Type) E. J. EDELEN		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) BURIAL		22b. DATE THEREOF 9/30/1958	
22c. NAME OF CEMETERY OR CREMATORIUM		22d. LOCATION (City, town, or county) GREENSBORO, NORTH CAROLINA (State)	
23. FUNERAL DIRECTOR'S SIGNATURE MARTIN W. HYSONG CO. 1300- N. STREET, N.W.—WASH. D.C.		ADDRESS	
		24a. REC'D BY REGISTRAR SEP 30 '58	
		24b. REGISTRAR'S SIGNATURE <i>James S. Kraus</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS 14  
1SM 10/57

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10118

## CERTIFICATE OF DEATH

10111

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Charles</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Plata</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural La Plata</b>				
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Physicans Memorial Hospital</b>		d. STREET ADDRESS <b>Bumpy Oak, Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
3. NAME OF DECEASED (Type or print) <b>EMMA</b>		First	Middle	Lost	4. DATE OF DEATH <b>DIXON</b>	Month	Day	Year
S. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH <b>January 9, 1879</b>	9. AGE (In years lost birthday) <b>79</b>	IF UNDER 1 YEAR Months	IF UNDER 24 HRS Days	Hours
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>		11. BIRTHPLACE (State or foreign country) <b>Oxon Hill, Maryland</b>		12. CITIZEN OF WHAT COUNTRY <b>U.S.A.</b>		
13. FATHER'S NAME <b>Silus Talbert</b>		14. MOTHER'S MAIDEN NAME <b>Jessie M. (Wife) Talbert</b>						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. James R. Dixon (Son)</b>		Bumpy Oak Road La Plata, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <b>570.1</b>		DUE TO <b>Gastric Enteritis - Viral</b>		INTERVAL BETWEEN ONSET AND DEATH <b>3 Days</b>				
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) (c)		<b>Paralytic Dilatans</b>		<b>3 Days</b>				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)						
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from <b>9-24-58</b> to <b>9-24-58</b> , that I last saw the deceased alive on <b>9-24-58</b> at <b>125</b> M, from the causes and on the date stated above. ACTUAL SIGNATURE <b>James E. Andrews M.D.</b>		ADDRESS (Street, city or town, state) <b>AREHART FUNERAL HOME, INC., LA PLATA, MARYLAND</b>						
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		22b. DATE THEREOF <b>Sept. 26, 1958</b>		22c. NAME OF CEMETERY OR CREMATORIUM <b>Ceder Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Suitland, Prince Geo. Co., Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Arthur L. Thorne</b>		ADDRESS <b>AREHART FUNERAL HOME, INC., LA PLATA, MARYLAND</b>		24a. REC'D BY REGISTRAR <b>SEP 29 '58</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thorne</b>		

BY SUMMER-TRAIL TO THE MOUNTAINS STATE PARK  
HIGH-TO-STADIUM

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10112

10119

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>Charles</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bryantown</b>		c. LENGTH OF STAY IN TB <b>X</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>00</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print)	First <b>Laura</b>	Middle <b>Gantt</b>	4. DATE OF DEATH Month Day Year <b>Sept. 19 1958</b>
5. SEX <b>F</b>	6. COLOR OR RACE <b>N</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 18 1886</b>
9. AGE (In years last birthday) <b>72 yrs.</b>		10. IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	11. IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>self</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Truman Carter</b>	
14. MOTHER'S MAIDEN NAME <b>Jane ?</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>	
16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Marie Woodland, Hughesville, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intestinal Obstruction</b>		INTERVAL BETWEEN ONSET AND DEATH <b>12 hrs.</b>	
570.5 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)			
Part II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Arteriovenous Gastroesophageal</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) <b>Hughesville</b> (State) <b>Md.</b>	
21. I certify that I attended the deceased from <b>18 Sep. 1958</b> to <b>19 Sep. 1958</b> , that I last saw the deceased alive on <b>18 Sep. 1958</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DAVID L MOSSMAN</b>		ADDRESS (Street, city or town, state) <b>Hughesville, Md.</b> DATE SIGNED <b>21 Sep 18</b>	
PHYSICIAN'S NAME (Type) <b>DAVID L MOSSMAN</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-22-58</b>	
22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Marys Cemetery</b>		22d. LOCATION (City, town, or county) <b>Bryantown, Md.</b> (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Huntt Funeral Home, Waldorf, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 23 '58</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hunt</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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DEPARTMENT OF HEALTH-ENVIRONMENT

CERTIFICATE OF DEATH

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52	53	54	55	56	57	58	59	60	61	62	63	64	65	66	67	68	69	70	71	72	73	74	75	76	77	78	79	80	81	82	83	84	85	86	87	88	89	90	91	92	93	94	95	96	97	98	99	100	101	102	103	104	105	106	107	108	109	110	111	112	113	114	115	116	117	118	119	120	121	122	123	124	125	126	127	128	129	130	131	132	133	134	135	136	137	138	139	140	141	142	143	144	145	146	147	148	149	150	151	152	153	154	155	156	157	158	159	160	161	162	163	164	165	166	167	168	169	170	171	172	173	174	175	176	177	178	179	180	181	182	183	184	185	186	187	188	189	190	191	192	193	194	195	196	197	198	199	200	201	202	203	204	205	206	207	208	209	210	211	212	213	214	215	216	217	218	219	220	221	222	223	224	225	226	227	228	229	230	231	232	233	234	235	236	237	238	239	240	241	242	243	244	245	246	247	248	249	250	251	252	253	254	255	256	257	258	259	260	261	262	263	264	265	266	267	268	269	270	271	272	273	274	275	276	277	278	279	280	281	282	283	284	285	286	287	288	289	290	291	292	293	294	295	296	297	298	299	300	301	302	303	304	305	306	307	308	309	310	311	312	313	314	315	316	317	318	319	320	321	322	323	324	325	326	327	328	329	330	331	332	333	334	335	336	337	338	339	340	341	342	343	344	345	346	347	348	349	350	351	352	353	354	355	356	357	358	359	360	361	362	363	364	365	366	367	368	369	370	371	372	373	374	375	376	377	378	379	380	381	382	383	384	385	386	387	388	389	390	391	392	393	394	395	396	397	398	399	400	401	402	403	404	405	406	407	408	409	410	411	412	413	414	415	416	417	418	419	420	421	422	423	424	425	426	427	428	429	430	431	432	433	434	435	436	437	438	439	440	441	442	443	444	445	446	447	448	449	450	451	452	453	454	455	456	457	458	459	460	461	462	463	464	465	466	467	468	469	470	471	472	473	474	475	476	477	478	479	480	481	482	483	484	485	486	487	488	489	490	491	492	493	494	495	496	497	498	499	500	501	502	503	504	505	506	507	508	509	510	511	512	513	514	515	516	517	518	519	520	521	522	523	524	525	526	527	528	529	530	531	532	533	534	535	536	537	538	539	540	541	542	543	544	545	546	547	548	549	550	551	552	553	554	555	556	557	558	559	560	561	562	563	564	565	566	567	568	569	570	571	572	573	574	575	576	577	578	579	580	581	582	583	584	585	586	587	588	589	590	591	592	593	594	595	596	597	598	599	600	601	602	603	604	605	606	607	608	609	610	611	612	613	614	615	616	617	618	619	620	621	622	623	624	625	626	627	628	629	630	631	632	633	634	635	636	637	638	639	640	641	642	643	644	645	646	647	648	649	650	651	652	653	654	655	656	657	658	659	660	661	662	663	664	665	666	667	668	669	670	671	672	673	674	675	676	677	678	679	680	681	682	683	684	685	686	687	688	689	690	691	692	693	694	695	696	697	698	699	700	701	702	703	704	705	706	707	708	709	710	711	712	713	714	715	716	717	718	719	720	721	722	723	724	725	726	727	728	729	730	731	732	733	734	735	736	737	738	739	740	741	742	743	744	745	746	747	748	749	750	751	752	753	754	755	756	757	758	759	760	761	762	763	764	765	766	767	768	769	770	771	772	773	774	775	776	777	778	779	780	781	782	783	784	785	786	787	788	789	790	791	792	793	794	795	796	797	798	799	800	801	802	803	804	805	806	807	808	809	810	811	812	813	814	815	816	817	818	819	820	821	822	823	824	825	826	827	828	829	830	831	832	833	834	835	836	837	838	839	840	841	842	843	844	845	846	847	848	849	850	851	852	853	854	855	856	857	858	859	860	861	862	863	864	865	866	867	868	869	870	871	872	873	874	875	876	877	878	879	880	881	882	883	884	885	886	887	888	889	890	891	892	893	894	895	896	897	898	899	900	901	902	903	904	905	906	907	908	909	910	911	912	913	914	915	916	917	918	919	920	921	922	923	924	925	926	927	928	929	930	931	932	933	934	935	936	937	938	939	940	941	942	943	944	945	946	947	948	949	950	951	952	953	954	955	956	957	958	959	960	961	962	963	964	965	966	967	968	969	970	971	972	973	974	975	976	977	978	979	980	981	982	983	984	985	986	987	988	989	990	991	992	993	994	995	996	997	998	999	1000
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## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10113

10120

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH  
o. COUNTY

Charles

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Plata

c. LENGTH OF STAY IN lb

1 Day

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Physicians Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)

o. STATE

Maryland

b. COUNTY

Charles

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

Waldorf

d. STREET ADDRESS

1

e. IS RESIDENCE ON A FARM?

YES

NO

3. NAME OF DECEASED  
(Type or print)

First

Middle

Last

4. DATE OF DEATH

Month

Day

Year

5. SEX

M

6. COLOR OR RACE

W

7. MARRIED  NEVER MARRIED 

8. DATE OF BIRTH

WIDOWED DIVORCED 

JUNE 26 1895

63

IF UNDER 1 YEAR  
Months DaysIF UNDER 24 HRS.  
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Clerk

10b. KIND OF BUSINESS OR INDUSTRY

Hardware Store

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

SIMMS Gardiner

14. MOTHER'S MAIDEN NAME

Blanche Montgomery

Address

15. WAS DECEASED EVER IN U. S. ARMED FORCES?

(Yes, no, or unknown)

(If yes, give war or dates of service)

yes

WWI

16. SOCIAL SECURITY NO.

213-16-5479

17. INFORMANT

Mary Ellen Mister, Waldorf, Md.

STATE OF MASSACHUSETTS - DEPARTMENT OF PUBLIC WORKS

CERTIFICATE OF DATA

6211

1995-0000

1995-0000

1995-0000

1995-0000

1995-0000

1995-0000

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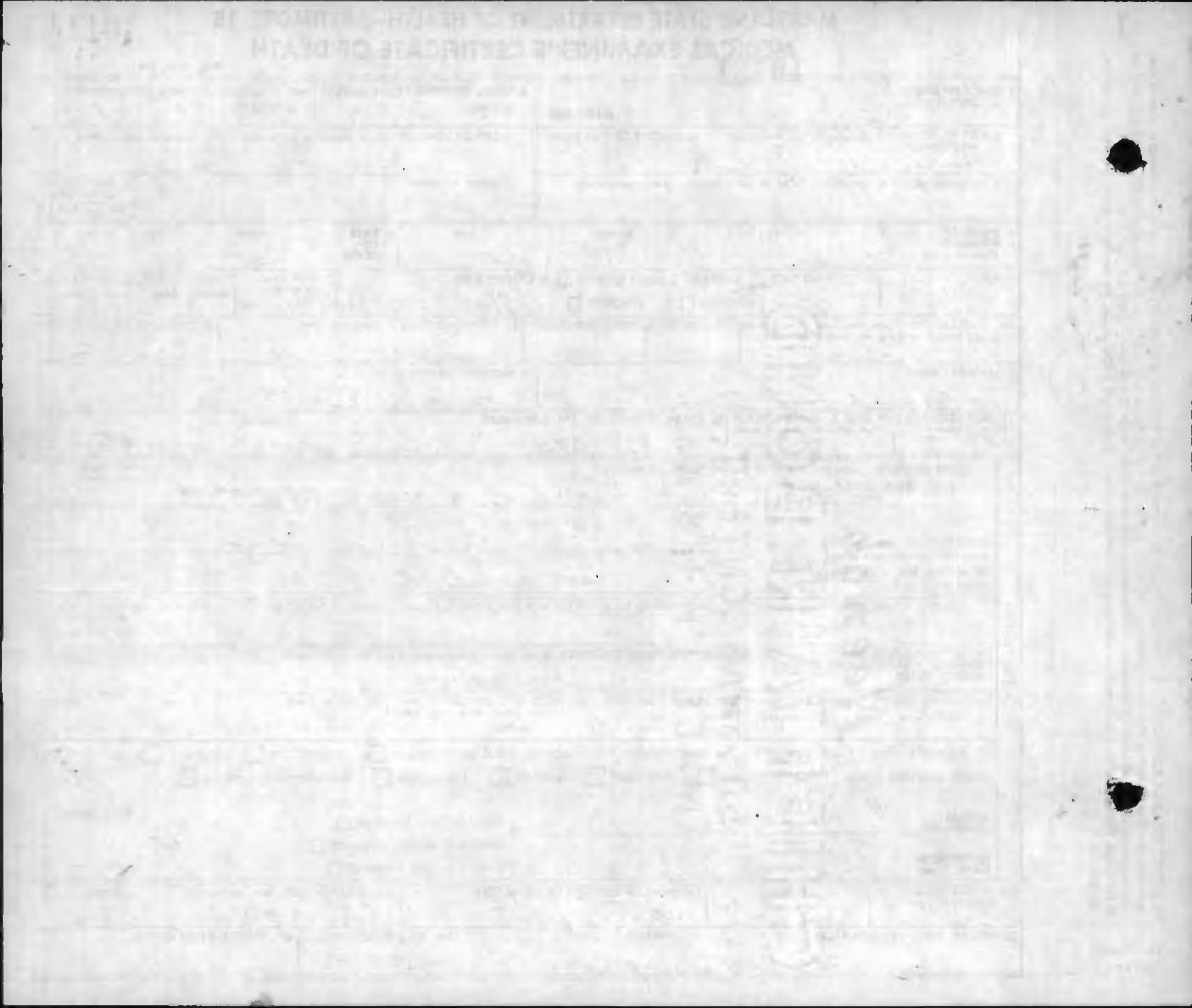
**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**ITEMS 18-21 Film 233 Q-1558 cont.**  
**10121 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

10114

Reg. Dist. No.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit Permit. File Pages 1 and 2 with the registrar prior to burial, cremation, or removal.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <i>Md</i>	
MARYLAND		b. COUNTY <i>Calvert</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Hughesville</i>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Huntingtown</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS <i>04x2</i>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John B Long</i>		First <i>B</i>	Middle <i>Long</i>
Last <i>Long</i>		Last <i>Sept. 6</i>	4. DATE OF DEATH Month <i>Sept.</i> Day <i>6</i> Year <i>1958</i>
5. SEX <i>M</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> 8. DATE OF BIRTH <i>May 12, 1924</i>	9. AGE (In years last birthday) <i>34</i> yrs.
WIDOWED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	10. IF UNDER 1 YEAR Address <i>Montgomery</i> Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>River</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Huntington</i>	
11. BIRTHPLACE (State or foreign country) <i>England</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
13. FATHER'S NAME <i>Howley Long</i>		14. MOTHER'S MAIDEN NAME <i>Sarah E. Kent</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-16-2070</i>	
17. INFORMANT <i>Sarah E. Long</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <i>Compound fracture of knee crushed chest</i>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (b) <i>812X</i>		DUE TO <i>(b) compound fracture of left leg - comp.</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. <i>Fracture of mandible</i>		DUE TO <i>(c) Pedestrian - hit by auto</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <i>Hit by auto - pedestrian</i>	
20c. TIME OF INJURY Month, Day, Year Hour <i>2</i> p.m. <i>9</i> 6 19 <i>58</i>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>Hughesville</i>		20f. (City or town) <i>Hughesville</i> (County) <i>Chas</i> (State) <i>Md.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>E. J. Edelen</i>		DATE SIGNED <i>9-6-58</i>	
EXAMINER'S NAME (Type) <i>E. J. Edelen</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>Sept 9 58</i>	
22c. NAME OF CEMETERY OR CREMATORIAL <i>Baltimore</i>		22d. LOCATION (City, town, or county) <i>Huntingtown</i> (State) <i>Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Rehartske &amp; Sons Inc.</i>		ADDRESS <i>1000 N. Charles St.</i>	
24a. REC'D BY REGISTRAR <i>SEP 9 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Carrie S. Kline</i>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10122

## CERTIFICATE OF DEATH

10115

Reg. Dist. No.

1. PLACE OF DEATH  
a. COUNTY

Charles

MARYLAND

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Plata

c. LENGTH OF STAY IN lb

5 days

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION

Physicians Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)  
a. STATE

Md. (Signature)

b. COUNTY

Chesapeake

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)

La Plata

3. NAME OF  
DECEASED  
(Type or print)First  
NORMANMiddle  
E.Last  
LYLES4. DATE  
OF  
DEATH

SEPT

3

Year  
1958

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED  NEVER MARRIED WIDOWED DIVORCED 

8. DATE OF BIRTH

3-10-97

9. AGE (In years  
last birthday)61  
yrs

10. IF UNDER 1 YEAR

Months

11. IF UNDER 24 HRS.

Days

Hours

Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Number

10b. KIND OF BUSINESS OR INDUSTRY

Retired

11. BIRTHPLACE (State or foreign country)

Maryland

12. CITIZEN OF WHAT COUNTRY?

U.S.A.

13. FATHER'S NAME

John W. Lyles

14. MOTHER'S MAIDEN NAME

Manie ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)  
(If yes, give war or date of service)

No

16. SOCIAL SECURITY NO.

No

17. INFORMANT

John Henry Lyles, La Plata, Md

Address

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:  
IMMEDIATE CAUSE (a)

Cerebral Thromboasis

INTERVAL BETWEEN  
ONSET AND DEATH  
5 days

DUE TO

Conditions, if any, which  
gave rise to immediate  
cause (a), stating the under-  
lying cause last. } (b)

DUE TO

(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY  
PERFORMED?  
YES  NO 20a. ACCIDENT WAS UNDERLYING  OR CONTRIBUTING  CAUSE OF DEATH  
(If either, notify MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Month, Day, Year

Hour

o. m.

p. m.

19

20d. INJURY OCCURRED

While at work Not while at work At work 

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I attended the deceased from 8-22 1958 to 9-3 1958 that I last saw the deceased alive on 9-2 1958, and that death occurred at 4 A.M. from the causes and on the date stated above.

SIGNATURE

F. M. JOHNSON MD

ADDRESS (Street, city, or town, state)

DATE SIGNED

PHYSICIAN'S  
NAME (Type)

F. M. JOHNSON MD

22a. BURIAL, CREMATION,  
REMOVAL (Specify)

Burial

9/6/58

22b. DATE THEREOF

9/6/58

ST Mattews

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or county)

Newton

Md.

(State)

23. FUNERAL DIRECTOR'S SIGNATURE

The Heart Funeral Home, Waldorf, Md

ADDRESS

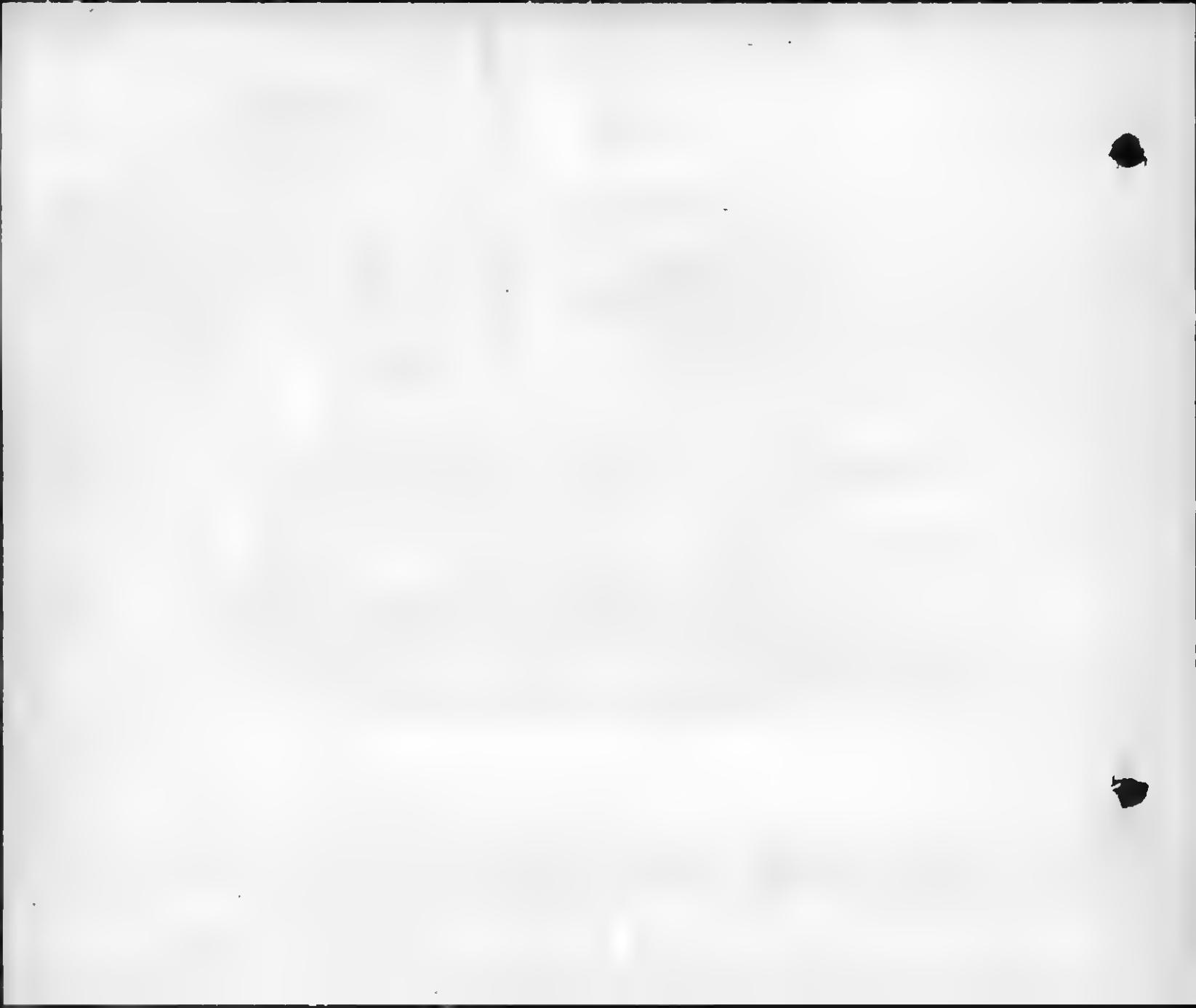
24a. REC'D BY REGISTRAR

Sep 8 '58

DATE

24b. REGISTRAR'S SIGNATURE

Arthur S. Kraus



TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any day, 3 months, please  
 execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director.  
 4 should be forwarded to the Chief Medical Examiner's Office along with form PMJ. Page 5 may be retained for files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health,  
 or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 10116 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10116

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY		Charles MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: residence before admission)	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		Md		b. COUNTY Charles	
c. LENGTH OF STAY IN 16 days 2 hrs.		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		x Indian Head	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		STREET ADDRESS		e. RESIDENCE ON A FARM YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
U.S. Naval Propellant Plant, Indian Head		40 Raymond Ave		Month Day Year	
3. NAME OF DECEASED (Type or print)		First	Middle	Lost	DATE OF DEATH
William Ernest Morgan					September 30 1958
4. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years to the nearest month)
Male		White	WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	12-22-29	28 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
Press Operator		U.S.N. Propellant Plant		Orville, Md	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME			
William Thomas Morgan		Rose Anne Gray or Grey			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT	
YES		1948-1952		U.S. Naval Propellant Plant Records	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]		Address Indian Head Md			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		Multiple injuries extreme result of Spherical Blast			
715.3 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b) DUE TO Spherical Blast		(c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
None.					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of Item 18) Was making adjustments on powder press which probably sparked the			
20c. TIME OF INJURY Hour a.m. 8:45 Month, Day, Year 9/30 1958		20d. INJURY OCCURRED While at work <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) Factory	
20f. (City or town) Indian Head		(County) Charles		(State) Md	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE  EXAMINER'S NAME (Type) Frank A. Susan		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED 9-30-58	
22a. BURIAL, CREMATION [22b. DATE THEREOF REMOVAL (Specify) Burial 10/3/58]		22c. NAME OF CEMETERY OR CREMATORIUM Arlington National Cemetery		22d. LOCATION (City, town, or county) Arlington, Va (State)	
23. FUNERAL DIRECTOR'S SIGNATURE The Hunt Funeral Home, 1131 Dorf Rd		ADDRESS		24a. REC'D BY REGISTRAR DATE OCT 6 '58	
				24b. REGISTRAR'S SIGNATURE C. E. S. Hunt	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10117

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Charles</b>		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission) a. STATE <b>Md.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Pisgah</b>		c. LENGTH OF STAY IN 1b <b>1 mo</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. STREET ADDRESS <b>Pisgah</b>			
f. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
3. NAME OF <b>James</b> (Type or print)	First	Middle	Last		
S. SEX <b>Male</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 14, 1902</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Former</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>Own Farm</b>	11. BIRTHPLACE (State or foreign country) <b>Indian Head Md</b>	12. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		
13. FATHER'S NAME <b>James Russell Penny</b>	14. MOTHER'S MAIDEN NAME <b>Effie Elizabeth Swann</b>	Address <b>Pisgah Rd.</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>	16. SOCIAL SECURITY NO. <b>123-45-6789</b>	17. INFORMANT <b>Mrs Violet Summons</b>	18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)  DUE TO <b>Coronary Occlusion</b>  Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO <b>Hypertensive Heart Disease</b>  (c)  PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>N. one</b>	INTERVAL BETWEEN ONSET AND DEATH <b>Terminal</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour o. m.      p. m. 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>5 Indian Head Ave</b>	20f. (City or town) <b>Indian Head</b>	(County) <b>Calvert</b>	(State) <b>Md.</b>
21. I certify that I attended the deceased from <b>March 12, 1956</b> , to <b>Sept. 29, 1958</b> , that I last saw the deceased alive on <b>Sept. 25, 1958</b> , and that death occurred at <b>10:30 P.M.</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>Frank A. Susan</b>					
ADDRESS (Street, city or town, state) <b>5 Indian Head Ave</b> DATE SIGNED <b>9-30-58</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>10-3-58</b>	22c. NAME OF CEMETERY OR CREMATORIUM <b>St. Charles</b>	22d. LOCATION (City, town, or county) <b>Glymont</b> (State) <b>Md.</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joe Scott Funeral Home</b>		ADDRESS <b>45-47 Main St.</b>	24a. REC'D BY REGISTRAR <b>OCT 3 '58</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

10118

## 10125 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "Pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <i>Charles</i>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Virginia</i> b. COUNTY <i>UNK</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Waldorf</i> <i>UNK</i>		c. LENGTH OF STAY IN 1b <i>UNK</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. STREET ADDRESS <i>83x-3</i>	
3. NAME OF DECEASED (Type or print) <i>TAYLOR James</i>		First <i>PHILLIPS</i>	Middle <i>SEPT. 12 1958</i>
4. DATE OF DEATH <i>48</i>		Month <i>Month</i>	Day <i>Year</i>
5. SEX <i>Male</i>		6. COLOR OR RACE <i>Cav</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>
8. DATE OF BIRTH <i>Nov 16 1909</i>		9. AGE (In years last birthday) <i>48</i>	10. IF UNDER 1 YEAR Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Sawmill</i>	11. BIRTHPLACE (State or foreign country) <i>Virginia</i>
12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		13. FATHER'S NAME <i>Mathew Phillips</i>	
14. MOTHER'S MAIDEN NAME <i>Nan Collins</i>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>	
16. SOCIAL SECURITY NO. <i>812 X</i>		17. INFORMANT <i>H.O. Crawford, Lexington Park, Md.</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)  PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Shock</i>		INTERVAL BETWEEN ONSET AND DEATH <i>2 min.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)  none		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Struck by auto while crossing Rt. 301 on foot.</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.) <i>WALDORF CHARLES, MD.</i>	
20c. TIME OF INJURY Hour <i>7:50</i> p.m. Month, Day, Year <i>9-12 1958</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/> <i>Rt. 301</i>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>WALDORF CHARLES, MD.</i>		20f. CITY OR TOWN (City) <i>WALDORF CHARLES, MD.</i>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>		DATE SIGNED <i>9/12/58</i>	
ACTUAL SIGNATURE <i>V.B. Dettor</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> ACTING MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <i>V.B. DETTOR M.D.</i>		22b. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	
22c. DATE THEREOF <i>9/16/58</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>St Georges</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>The Hunt Funeral Home, Waldorf, Md.</i>		24a. LOCATION (City, town, or county) <i>Poplar Hill Md.</i>	
ADDRESS		(State)	
24a. REC'D BY REGISTRAR DATE <i>SEP 17 '58</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	



**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 10126 CERTIFICATE OF DEATH										11239						
										Reg. Dist. No.						
1. PLACE OF DEATH a. COUNTY		Charles		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)		o. STATE		Maryland						
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		La Plata		c. LENGTH OF STAY IN lb		d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY		Charles						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		Physicians Memorial Hosp.		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
3. NAME OF DECEASED (Type or print)		First WILLIAM	Middle B.	Last WELCH	4. DATE OF DEATH	Month 9	Day - 30	Year 1958	5. SEX		6. COLOR OR RACE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH	9. AGE (In years last birthday) 62 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		Farmer & his son		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY								
13. FATHER'S NAME		Hydick Welch		Self Employed		Charles County, Md.		U.S.A.								
14. MOTHER'S MAIDEN NAME		Mary V. Franklin														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or No or unknown) If yes, give war or dates of service)		Yes W.W. I		16. SOCIAL SECURITY NO.		17. INFORMANT		Address								
				214-18-8474		M. Hydick Welch (Son) Pomfort, Maryland										
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]										INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO (c)										9 hours						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										years						
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) No injury								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____		19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)					
21. I certify that I attended the deceased from 9-30, 1958, to 9-30, 1958, that I last saw the deceased alive on 9-30, 1958, and that death occurred at 9A M, from the causes and on the date stated above.										ADDRESS (Street, city or town, state)						
ACTUAL SIGNATURE V.B. Dettor		M.D.		La Plata, Md.		LA PLATA, MD.		DATE SIGNED 9-30-58								
PHYSICIAN'S NAME (Type)		V.B. DETTOR														
22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		22b. DATE THEREOF 10/2/1958		22c. NAME OF CEMETERY OR CREMATORIUM William & Mary Church Cem. Wayside, Maryland		22d. LOCATION (City, town, or county) Wayside		(State) Maryland								
23. FUNERAL DIRECTOR'S SIGNATURE AREHART FUNERAL HOME, INC.		ADDRESS LA PLATA, MARYLAND		24a. REC'D BY REGISTRAR OCT 7 '58		24b. REGISTRAR'S SIGNATURE Arthur S. Trahan										

ST. DOMINIC'S - MONTGOMERY COUNTY, STATE OF MARYLAND  
HEARD BY TELETYPE